Primary EyeCare

Primary Eye Care-Delano
1045 Crossing Drive, Ste 200
Delano, MN 55328
763-777-9393
Fax: 763-777-9358

Primary EyeCare-Hutchinson
1059 Hwy 15 S.
Hutchinson, MN 55350
320-587-4744
Fax: 320-587-9168

Primary EyeCare-Litchfield
520 Hwy 12 E., Ste 106
Litchfield, MN 55355
320-693-9333
Fax: 320-593-0520

Date: ___/___/___

Last Name:_____First Name:_____Middle Initial:_____

M or F Occupation:_____
Employer:_____

Hobbies: (Please circle) Golf, Boating/Fishing, Biking/Motorcycle, Tennis, Running, Gaming, Shooting/Hunting, Musical Instrument, Other_____

Last Eye Exam Date/Location:_____Primary Care Physician/Location_____

Do you have any of these problems currently below?		Do you wear Glasses?	**Y / N**
Eye pain or soreness	**Y / N**	If Yes, do you have a back up pair?	**Y / N**
Blurred Vision **without** Glasses/Contacts	**Y / N**		
Blurred Vision **with** Glasses/Contacts	**Y / N**	Do you currently wear Contact Lenses?	**Y / N**
Flashes/Floaters in vision	**Y / N**	If Yes, how would you rate comfort and vision, 1 poor 10 excellent?	#
Distorted vision/halos	**Y / N**		
Loss of side vision	**Y / N**	If not wearing Contacts, any interest?	**Y / N**
Double vision	**Y / N**		
Dryness	**Y / N**	How much time do you spend outdoors a day?	hrs
Mucous discharge	**Y / N**		
Redness	**Y / N**	Do you have sunglasses?	**Y / N**
Sandy or gritty feeling	**Y / N**	If Yes, W/Prescription?	**Y / N**
Itching	**Y / N**		
Burning	**Y / N**	Do you want info on Laser Vision Correction?	**Y / N**
Foreign body sensation	**Y / N**		
Excess tearing/watering	**Y / N**	Do you want info on non-surgical option?	**Y / N**
Glare/light sensitivity	**Y / N**		
Tired eyes	**Y / N**		
Crossed eyes, lazy eye	**Y / N**		

Personal Medical History (Review of Systems): Please check any of the following APPLIES to you, and list any medications for each condition that you check. IF YOU HAVE NONE OF THESE CONDITIONS PLEASE CHECK NONE.

Cardiovascular: ___None ___Hypertension ___Cholesterol ___Stroke ___Heart Disease ___Other	**Endocrine:** ___None ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other:	**Respiratory:** ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional: ___None ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:	**Ocular:** ___**None** ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	**Psychiatric:** ___None ___ADHD ___Depression ___Schizophrenia ___Other:
Neurological: ___None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	**Musculoskeletal:** ___None ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	**Immunologic:** ___None ___AIDS or HIV ___Rheumatoid Arthritis ___Lupus ___Other:
Hematological: ___None ___Anemia ___Leukemia ___Other:	**Gastrointestinal:** ___None ___Crohn's ___Colitis ___Other:	**Ear/Nose/Throat:** ___None ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermotologic: ___None ___Eczema ___Rosacea ___Psoriasis ___Other:	**Allergies** (please list) ___None Drug: Environmental:	**Alcohol Use: Y N** amount: **Tobacco Use Y N** amount:

Please list any Medications and/or Drugs that you are taking (including herbal): or See Attached List____

_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____

Women: Are you Pregnant or Nursing currently? Y or N

Family History: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

Disease / Condition			**WHO**	**Disease / Condition**			**WHO**
Retinal Detachment	Y	N	_____	Glaucoma	Y	N	_____
Blindness	Y	N	_____	Cataracts	Y	N	_____
Macular Degeneration	Y	N	_____	Diabetes	Y	N	_____
Crossed Eyes	Y	N	_____	Other Eye Problem			_____

Patient's Signature:_____ Date:_____

If Minor/Age 17 or less, Parent or Guardian:_____Date:_____
Physicians Signature:_____ Date:_____
History Reviewed. Additions as noted above.